

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-044281

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

318  
1003  
11451  
FILED DEC 7 1962VS 300  
Rev. 4/59

DATE AMENDED

2

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b <b>22 yrs</b>		Inside Limits <b>Yes</b> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		d. STREET ADDRESS (If outside, give location) <b>4021 Labadie</b>	
3. NAME OF DECEASED (Type or print) First <b>Charlie</b> Middle <b>Green</b> Last		4. DATE OF DEATH Month <b>11</b> Day <b>26</b> Year <b>62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10-25-1906</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
13a. FATHER'S NAME <b>Aaron Green</b>		13b. MOTHER'S MAIDEN NAME <b>Ida Kervarth</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		17. INFORMANT <b>Clayrissa Ewing</b> Address <b>4021 Labadie</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Amebiasis</b>		DUE TO (c) <b>046.0</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Amoebic Abscess of Lung</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>11</b> a.m. <b>15</b> Month <b>11</b> Day <b>26</b> Year <b>62</b>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <b>11-15-62</b> to <b>11-26-62</b> and last saw him alive on <b>11-26-62</b>		Death occurred at <b>9:05</b> P. m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <b>J. D. Randle</b> (Degree or title)		22b. ADDRESS <b>2601 N. Whittier</b>	22c. DATE SIGNED <b>11-27-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>12-1-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>
24. FUNERAL DIRECTOR <b>JAS. H. RANDLE &amp; SON</b>		ADDRESS <b>3133 Bell Ave.</b>	
DATE RECD. BY LOCAL REG. <b>NOV 28 1962</b>		REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>	

USE BLACK INK  
OR  
TYPEWRITER RIBBON

FILED DEC 1 1988

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Esther K. Harris*

Licensed Embalmer No. 4458

P. O. Address 41817 Washington

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.